PRINTED: 09/27/2011 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING		COMPLE	
		005000	B. WIN	G			
		085002				09/13	3/2011
	PROVIDER OR SUPPLIER EW NURSING			STREET ADDRESS, CITY, STATE, 2801 W. 6TH STREET WILMINGTON, DE 19805			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN X (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOU TO THE APPRO	LD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	S	F0	000			
	was conducted at the 2011 through Septe deficiencies contain observations, intervalinical records and	· · · · · · · · · · · · · · · · · · ·					
F 278 SS=D	the first day of the s survey sample total 483.20(g) - (j) ASSE		F 2	78			
	The assessment muresident's status.	ust accurately reflect the					
	A registered nurse reach assessment we participation of heal						
	A registered nurse r assessment is comp	nust sign and certify that the pleted.					
		completes a portion of the gn and certify the accuracy of ssessment.					
	willfully and knowing false statement in a subject to a civil mo \$1,000 for each ass willfully and knowing to certify a material resident assessment	I Medicaid, an individual who ply certifies a material and resident assessment is ney penalty of not more than essment; or an individual who ply causes another individual and false statement in a t is subject to a civil money					
_ABORATOR)	assessment.	than \$5,000 for each ER/SUPPLIER REPRESENTATIVE'S S/GN	ATUDE				WO) DATE
~ DOING OR	DIRECTOR D CK PROVID	EN SUPPLIER REPRESENTATIVE'S SIGN	ATURE	TITLE		I = I	X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
			A. BUIL	A. BUILDING				
		085002	B. WiN	IG		09/13		
NAME OF P	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE			
DADKVI	EW NURSING			280	1 W. 6TH STREET		Ċ	
PARKVI	ENI NORSING			. WI	LMINGTON, DE 19805		, .	
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORREC	CTION	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP		COMPLÉTION DATE	
					DEFICIENCY)			
F 278	Continued From pa	ige 1	F 2	278				
	Clinical disagreeme	ent does not constitute a						
	material and false s			~ .				
			200					
	This REQUIREMEI	NT is not met as evidenced						
	by:							
		tions, clinical record review						
		it was determined that the						
		urately assess the functional						
		one of 33 Stage II sampled					1	
	residents (R8). Fin						er en	
		the facility on 1/25/07 with	1.0					
	diagnosis which inc			.				
		eoarthrosis, and Cerebral						
		with right sided weakness and						
	Peripheral Vascula							
		s on 9/6/11 at 12:30 PM and PM revealed that R8 was	V					
	i .	eding his/her self with the use						
San Daring		y. Food items from the tray						
		ens, sweet potatoes and apple						
) were observed to be on the						
		or and clothing of the resident.						
		any assistance with feeding	4. 4					
		lid not have any adaptive						
		a scooped plate or modified						
		to assist with eating.						
		num Data Set (MDS) dated						
		nat the resident 's Functional		1				
	Status for eating wa	as assessed as independent						
	under self-performa	ance and setup help only for		ļ.				
	support by staff.							
		terly Interdisciplinary Rehab						
		ited 8/30/11 documented for						
		Paily Living) that the resident						
in de la companya di Alia. Manganananan di Alia		dressing, toileting and feeding.						
		PM, R8's quarterly rehab						
	screening forms (6,	/14/11 and 8/30/11) and						

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	IULTIPL ILDING	E CONSTRUCTION	COMPLE	TED -
		085002	B. WII	1G:		1	C 3/2011
	ROVIDER OR SUPPLIER			280	ET ADDRESS, CITY, STATE, ZIP CODE 11 W. 6TH STREET LMINGTON, DE 19805		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 278	progress notes (da 1/6/2011-4/8/2011) (Occupational Ther the April 2011 disclunder Functional C Total Dependence 8/30/11 quarterly a with feeding. E8 s meant that the resident that the residence 12:30 PM, the residence on 9/8/11 at 12:35 assistance with ear reaching a can of s resident had reque from staff in the pather esident also s provided assistance times they did not. On 9/8/11 at 12:40 always spills food v	te of service were reviewed with the E8 rapist/OT). E8 confirmed that harge summary documented rutcomes for Self Feeding as with attempt to initiate and the lso documented dependent tated that Total Dependence dent was a feeder. with the resident on 9/6/11 at dent requested assistance with crisp from a plastic cup and PM, the resident requested ing a piece of cake and roda. When asked if the sted assistance with feeding st, the resident answered yes. tated that sometimes the staff e with feeding and at other PM, E9 (nurse) stated that R8 while eating and providing	F	1. 2. 3	A therapy screen was obtained resident R8 to reevaluate function feeding status. A random audit was completed on all units to ensure residents receiving the required assistance times. All staff will be in serviced by the Educator on the importance of residents with feeding difficulties and providing the required amo assistance at meal times. DON/Designee will complete a audit to ensure that residents at the correct assistance at meal the Findings will be presented to the Improvement Committee until scompliance is achieved.	by the DON were the at meal e Staff referring s to therapy unt of Quarterly QI re receiving imes. e Quality	9/12/11 9/13/11 10/31/11
	1 '	meals had not been red to the therapy department					Ongoing
F 280	does spill food whill resident is spilling to appropriate to place department for evaluation the resident require only as assessed of On 9/9/11 at 2:00 F Assistant/CNA) conhave to clean up for resident after eating	PM, E7 (Certified Nursing infirmed that the CNA's always od off the floor and on the grneals. E7 also stated that and not an assist with feeding.	F	280			

(X1) PROVIDER/SUPPLIER/CLIA

IDENTIFICATION NUMBER:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

PRINTED: 09/27/2011 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

COMPLETED

2.00	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG	COMPLETED			
		085002	B. WING _		C 09/13/2011			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2801 W. 6TH STREET WILMINGTON, DE 19805					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLÉTION			
F 280 SS=D	1	ge 3 NNING CARE-REVISE CP	F 280					
	incompetent or other	r the laws of the State, to ing care and treatment or						
	within 7 days after to comprehensive ass interdisciplinary tea physician, a register for the resident, and disciplines as deter and, to the extent puthe resident, the resident interesident in the resident interesident interesid	are plan must be developed the completion of the sessment; prepared by an im, that includes the attending ared nurse with responsibility dother appropriate staff in mined by the resident's needs, aracticable, the participation of sident's family or the resident's e; and periodically reviewed am of qualified persons after						
		NT is not met as evidenced						
	and staff interview, facility failed to revi regarding the functi	tions, clinical record review it was determined that the ew and revise care plans ional status for feeding and tage II sampled residents (R8 ps include:						
	diagnosis which ind Schizophrenia, Ost Vascular Disease v	to the facility on 1/25/07 with cluded Dementia, eoarthrosis, and Cerebral with right sided weakness and r Disease. Review of the						

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

PRINTED: 09/27/2011 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDING	<u> </u>	COMPLE	. IEU		
		085002	B. WING		00/4	C 3/2011		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2801 W. 6TH STREET WILMINGTON, DE 19805					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE		
F 280	resident's care plan have goals or interventional feeding so Dining observation on 9/8/11 at 12:35 leaving difficulty fee of the left hand only (9/6/11- collard greerisp; 9/8/11- cake) over bed table, flood The resident did not feeding from the standaptive equipment modified utensils or	s initiated on 8/30/11 failed to rentions which addressed R8's tatus. s on 9/6/11 at 12:30 PM and PM revealed that R8 was ding his/her self with the use r. Food items from the tray ens, sweet potatoes and apple were observed to be on the r and clothing of the resident. It receive any assistance with aff and did not have any it such as a scooped plate or in the tray to assist with eating.	#1 1. 2. 3.	Resident R8's care plan was re- revised to reflect the resident's status after the therapy screen was completed to assess the resident status. A random audit of care plans was completed to ensure the accurate feeding status assessment and documentation. All nurses will be in serviced on planning accuracy and revision status.	current was nts feeding s as as acy of care of ADL	9/12/11 9/13/11 10/31/11		
	8/29/11 revealed the eating was assessed self-performance and by staff. Review of Rehab Screening Fedocumented for AD that the resident was toileting and feeding Review of care plant.	L (Activities of Daily Living) as dependent for dressing, g. n "PA #13c" documented a	4.	to monitor the accuracy of ADL documentation on care plans a findings at the Quarterly QI messubstantial compliance is met.	status nd report	Ongoing		
	Therapy) for feeding. This intervention was care plan did not in any difficulties with been consulted. The 8/30/11. During an interview requested assistant crisp from a plastic	o to refer to OT (Occupational of difficulties with the resident. as initiated on 9/3/09. The dicate that the resident had feeding or that the OT had ne last revision date was on 9/6/11 at 12:30 PM, R8 ce with removing the apple cup and on 9/8/11 at 12:35 assistance with eating a piece						

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SU COMPLE	
		085002	B. WING		09/13) 3/2011
	ROVIDER OR SUPPLIER		28	EET ADDRESS, CITY, STATE, ZIP CODE 801 W. 6TH STREET /ILMINGTON, DE 19805		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 280	if the resident had reding from staff in The resident also suprovided assistance times they did not. On 9/9/11 at 1:50 Fresident's nutritional OT discharge summer intake forms for the does spill food while resident is spilling from appropriate to place department for evaluation of the support and the culindicate the resident.	ge 5 ng a can of soda. When asked requested assistance with the past, R8 answered yes. Itated that sometimes the staff of with feeding and at other. If the past, R8 answered yes. Itated that sometimes the staff of with feeding and at other. If the past, R8 answered yes. Itated that same the staff of with feeding and at other. If the past, R8 answered yes. Itated that R8 is eating and that when a seed while eating, it would be the arehab consult to the OT is a rehab consult to the other resident as set up only for the care plans did not it is functional feeding status. It is a rehab consult had not been	F 280			
	6/22/11, included a fluid restriction. Review of R149's E 8/18/11stated, "Nurnon-compliant c (w R149's care plan, in " Nutritional status in nutrition status in nutrition status in restriction" Revie "Maintain 1200 ml facility failed to revi	chysician's orders, dated in order for a 1200 ml (milliliter) Dietary Progress Note, dated raing reports res (resident) ith) fluid restriction" Initiated on 7/1/11 and entitled, is: Resident at risk for alteration of (related to) ESRD (End se) dx (diagnosis) Receives and has the need for a fluid w of the interventions included, fluid restriction" However, the se this or any of his other care 149's noncompliance with his	# 1 2	Resident R149's care plan was include non-compliance with flurestrictions. All residents currently on fluid rewere audited by the DON to encompliance with restriction and documentation of non-complian. All staff will receive in servicing importance fluid restriction and documentation of adherence to restriction/non compliance with	estrictions sure accurate ace, on the correct fluid restriction, uarterly QI ocumentation ial ts will be	9/13/11 9/14/11 10/31/11 Ongoing

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED						
		085002	B. WII	B. WING			C 09/13/2011	
	ROVIDER OR SUPPLIER			2	REET ADDRESS, CITY, STATE, ZIP CODE 801 W. 6TH STREET VILMINGTON, DE 19805			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 280	Continued From pa		F	280				
	(nurse) stated that with his fluid restric E7 reviewed R149'	on 9/13/11 at 11:10 AM, E7 R149 is often non compliant tion when in the dining room. s care plans and confirmed een revised to address R149's						
	dietitian) acknowled was non compliant the importance of a restriction with him R149's care plan d of noncompliance a revise it. A copy of	on 9/13/11, E8 (registered dged that she was aware R149 and had previously discussed dherence to the fluid E8 acknowledged that d not reflect his current status and stated that she would the revised care plan was vey team. The facility failed to						
F 312 SS=D	revise R149's care team brought it to t 483.25(a)(3) ADL 0	plan until after the survey heir attention. CARE PROVIDED FOR	Ц	312				
	daily living receives	nable to carry out activities of the necessary services to tion, grooming, and personal						
	by: Based on observa and staff interview, facility failed to ens sampled residents	NT is not met as evidenced tions, clinical record review it was determined that the ure that one of 33 Stage II with decreased functional esistance with feeding (R8).						

Findings include:

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED				
	· · · · · · · · · · · · · · · · · · ·	085002	B. WING _	09/	13/2011		
	PROVIDER OR SUPPLIER		2	REET ADDRESS, CITY, STATE, ZIP CODE 801 W. 6TH STREET VILMINGTON, DE 19805			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
F.312	R8 was admitted to diagnosis which inc Schizophrenia, Ost	the facility on 1/25/07 with cluded Dementia, eoarthrosis, and Cerebral vith right sided weakness and	F 312				
	on 9/8/11 at 12:35 l having difficulty fee	s on 9/6/11 at 12:30 PM and PM revealed that R8 was ding his/her self with the use /. Food items from the tray	1.	A therapy screen was obtained for resident R8 to reevaluate functional feeding status. A random audit was completed by the DON on all units to ensure residents were	9/12/11		
	(9/6/11- collard gre crisp; 9/8/11- cake) over bed table, floo The resident did no feeding from the sta	ens, sweet potatoes and apple were observed to be on the or and clothing of the resident. of receive any assistance with aff and did not have any	3.	receiving the required assistance at meal times. All staff will be in serviced by the Staff Educator on the importance of referring residents with feeding difficulties to therapy and providing the required amount of	9/13/11		
	modified utensils or	t such as a scooped plate or n the tray to assist with eating. num Data Set (MDS) dated	4	assistance at meal times. DON/Designee will complete a Quarterly QI audit to ensure that residents are receiving the correct assistance at meal times.	10/3 1/11		
	8/29/11 revealed th Status for eating wa under self-performs support by staff. R Interdisciplinary Re 8/30/11 documents Living) that the resi	nat the resident's Functional as assessed as independent ance and setup help only for eview of the quarterly thab Screening Form dated ad for ADL (Activities of Daily dent was dependent for		Findings will be presented to the Quality Improvement Committee until substantial compliance is achieved.	Ongoing		
	12:30 PM, R8 requiremoving the apple on 9/8/11 at 12:35 with eating a piece soda. When asked assistance with fee answered yes. The	with the resident on 9/6/11 at ested assistance with crisp from a plastic cup and PM, R8 requested assistance of cake and reaching a can of if the resident had requested ding from staff in the past, R8 is resident also stated that if provided assistance with					

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CENIER	S FOR MEDICARE	& MEDICAID SERVICES				OMR NO.	<u>0938-0391</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION	(X3) DATE SL COMPLE	
			7.50	יונטווי			
	4 - 1	205220	B. Wil	NG		(
		085002				09/13	3/2011
NAME OF P	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		
					801 W. 6TH STREET		
PARKVIE	W NURSING				VILMINGTON, DE 19805		, A.A.
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	iΧ	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
				•			
F 312	Continued From pa	.ao 9	_	242			
1 012	•	· · · · · · · · · · · · · · · · · · ·	۳	312			
	feeding and at othe	r times they did not.		•			
	On 9/9/11 at 1:50 F	PM, E4 (nurse) stated that R8					
		e eating and that when a					
		ood while eating, it would be					
		e a rehab consult to the OT					
		luation. E4 also agreed that		1			
		ed more assistance than setup	1.0				
	only as assessed of						
	On 9/9/11 at 2:00 F	PM, E7 (Certified Nursing					
	Assistant/CNA) cor	firmed that the CNA's always		7.			
	have to clean up fo	od off the floor and on the		1,			
		g meals. E7 also stated that					
		tup only and not an assist with		i iz			
	feeding.	tup only and not an assist with					
F 000	•	E A COLDENIE	_				
F 323	483.25(h) FREE O		-	323			
SS=E	HAZARDS/SUPER	VISION/DEVICES		- 2			
	The facility must er	sure that the resident		100			
	environment remain	ns as free of accident hazards					
18 T	as is possible; and	each resident receives	1				
		on and assistance devices to					
	prevent accidents.	0.11 d/1d d00/0td/100 d01/000 t0					
	prevent accidents.						
				100			
	This REQUIREMEN	NT is not met as evidenced					
	by:						
	Based on observa-	tions and staff interviews, it		1.5		a BBA N	
		at the facility failed to maintain		- 2			
		ee from accidents hazards, as		1			
		cessible and unlocked					
		ension cords on floors posing a		e e e e e e			
		d an unlocked shower room on					
	the dementia unit. I	Findings include:		 		计位息数据 :	
s to the same of			1 - 1				医二氏性多形 医静态

1. Observations made on 9/6/11 revealed a

DEPAR	MENT OF HEALTH AND HUMAN SERVICES		09/27/2011
	RS FOR MEDICARE & MEDICAID SERVICES		APPROVED 0938-0391
	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE SL A. BUILDING (X3) DATE SL	
	085002	B. WING)
JAME OF R	ROVIDER OR SUPPLIER		3/2011
		STREET ADDRESS, CITY, STATE, ZIP CODE 2801 W. 6TH STREET	
PARKVIE	EW NURSING	WILMINGTON, DE 19805	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 9	F 323	
	treatment cart on the Westover unit unlocked with	F323	
	contents accessible to residents and visitors. The	#1	
	cart stored medicated ointments.	 The treatment cart was immediately locked when identified as unsecured. 	
	In an interview with E10 (Nurse Supervisor) on		9/6/11
	9/6/11, she confirmed the cart needed to be	2. All medication/treatment carts were	
	locked.	checked by the DON to ensure locks were	
	2. An observation of R49's room during the		9/6/11
	environmental tour with E11 (Maintenance	In servicing will be provided to all nursing staff on the importance of securing all	
	Director) and E12 (Environmental Director) on	treatment/medication carts.	
	9/8/11 revealed a black bed electric cord on the	geagnenomodication care.	10/31/11
	floor that posed a potential tripping hazard. The	4. A Quarterly QI will be initiated by the	
i da ila.	electric bed cord was in the walking space of the	DON/Designee to ensure that all	
	floor in front of the bed.	treatment/medication carts remain locked	
		when not in use until substantial compliance is met. Findings will be presented to the	
	3. An observation of R123's room during the	Quality Improvement Team.	
	environmental tour with E11 (Maintenance		Ongoing
1.75	Director) and E12 (Environmental Director) on		
	9/8/11 revealed a black bed electric cord on the		
	floor that posed a potential tripping hazard. The electric bed cord was in the walking space of the		
	floor in front of the bed.		
	neof in none of the bed,		
	4. An observation of R137's room during the		
	environmental tour on 9/8/11 revealed a long		
	phone cord on the floor that posed a potential		
	tripping hazard. The phone cord was in the		
	walking space of the floor in front of the bed.		
	In interviews with E11 on 9/8/11, he confirmed		
	the finding. E11 was observed relocating the		
	cords each time.		
	5. Observation on 9/6/11 at 8:50 AM of the second floor Lancaster unit (locked unit) revealed		
	an unlocked shower room. In an interview with		
	E17 (nurse) immediately after the observation,		
	= (l de la companya de

she stated that the door was to be locked. E17 went to check the door and stated something was

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING		c
		085002	B. WING		09/13/2011
	ROVIDER OR SUPPLIER		28	EET ADDRESS, CITY, STATE, ZIP CODE 01 W. 6TH STREET ILMINGTON, DE 19805	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLÉTION
F 323	contents accessible cart stored medicat In an interview with 9/6/11, she confirm locked. 2. An observation of environmental tour Director) and E12 (9/8/11 revealed a pelectric bed cord with floor in front of the 3. An observation of environmental tour Director) and E12 (9/8/11 revealed a pelectric bed cord with the servironmental tour Director) and E12 (9/8/11 revealed a pelectric bed cord with the servironmental tour Director) and E12 (9/8/11 revealed a pelectric bed cord with the servironmental tour Director) and E12 (9/8/11 revealed a pelectric bed cord with the service bed cord	the Westover unit unlocked with the to residents and visitors. The sed ointments. E10 (Nurse Supervisor) on ed the cart needed to be of R49's room during the with E11 (Maintenance Environmental Director) on elack bed electric cord on the section the walking space of the bed. of R123's room during the with E11 (Maintenance environmental Director) on elack bed electric cord on the section of the bed.	#323 #2 1. 2.	their units to ensure any and all co properly placed to avoid tripping h In-service will be provided to all st Random observations will be cond Maintenance Director and/or Desi weekly to ensure cords are proper placed.	y/8/11 bunds on bords are azards. aff. 10/31/11 ducted by gnee rly 10/31/11 ndings to
	environmental tour phone cord on the tripping hazard. The walking space of the line interviews with Environmental tour the finding. E11 was cords each time. 5. Observation on second floor Lanca an unlocked shower E17 (nurse) immediate that the	of R137's room during the on 9/8/11 revealed a long floor that posed a potential e phone cord was in the le floor in front of the bed. 11 on 9/8/11, he confirmed as observed relocating the electronic flocked unit) revealed er room. In an interview with liately after the observation, door was to be locked. E17 floor and stated something was			

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(X3) DATE SURVEY

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		085002	B. WING		09/13/	2011
	ROVIDER OR SUPPLIER		28	EET ADDRESS, CITY, STATE, ZIP CODE 801 W. 6TH STREET VILMINGTON, DE 19805		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
F 323	treatment cart on the contents accessible cart stored medica. In an interview with 9/6/11, she confirm locked. 2. An observation environmental tour Director) and E12 9/8/11 revealed a floor that posed a electric bed cord with floor in front of the 3. An observation environmental tour Director) and E12 9/8/11 revealed a floor that posed a electric bed cord with floor in front of the 4. An observation environmental tour phone cord on the tripping hazard. The walking space of the In interviews with the finding. E11 with cords each time. 5. Observation on second floor Lancan unlocked show E17 (nurse) immeshe stated that the stated t	the Westover unit unlocked with the to residents and visitors. The ted ointments. In E10 (Nurse Supervisor) on the the cart needed to be the cart needed	F 323	1. Electrical cord identified in R12 during environmental tour was behind the bed immediately. 2. Nursing staff will conduct safety their units to ensure any and all properly placed to avoid trippin In-service will be provided to al. 3. Random observations will be of Maintenance Director and/or Divectly to ensure cords are proplaced. 4. Maintenance Director will report QI committee quarterly until surcompliance is achieved.	placed y rounds on ll cords are g hazards. Il staff, onducted by esignee perly rt findings to	9/8/11 10/31/11 0ngoing

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/27/2011 FORM APPROVED

OMB NO. 0938-0391 ENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION ATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: D PLAN OF CORRECTION A. BUILDING B. WING 085002 09/13/2011 STREET ADDRESS, CITY, STATE, ZIP CODE ME OF PROVIDER OR SUPPLIER 2801 W. 6TH STREET 'ARKVIEW NURSING WILMINGTON, DE 19805 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 323 F 323 Continued From page 9 treatment cart on the Westover unit unlocked with contents accessible to residents and visitors. The cart stored medicated ointments. In an interview with E10 (Nurse Supervisor) on 9/6/11, she confirmed the cart needed to be locked. 2. An observation of R49's room during the environmental tour with E11 (Maintenance Director) and E12 (Environmental Director) on 9/8/11 revealed a black bed electric cord on the floor that posed a potential tripping hazard. The electric bed cord was in the walking space of the floor in front of the bed. 3. An observation of R123's room during the environmental tour with E11 (Maintenance Director) and E12 (Environmental Director) on 9/8/11 revealed a black bed electric cord on the #4 floor that posed a potential tripping hazard. The Phone cord identified in R137's room electric bed cord was in the walking space of the during environmental tour was placed floor in front of the bed. behind the bed immediately. 9/8/11: Nursing staff will conduct safety rounds on An observation of R137's room during the their units to ensure any and all cords are properly placed to avoid tripping hazards. environmental tour on 9/8/11 revealed a long In-service will be provided to all staff. phone cord on the floor that posed a potential 10/31/11 Random observations will be conducted by tripping hazard. The phone cord was in the Maintenance Director and/or Designee walking space of the floor in front of the bed. weekly to ensure cords are properly placed. 10/31/11 In interviews with E11 on 9/8/11, he confirmed Maintenance Director will report findings to

cords each time.

the finding. E11 was observed relocating the

5. Observation on 9/6/11 at 8:50 AM of the

second floor Lancaster unit (locked unit) revealed an unlocked shower room. In an interview with E17 (nurse) immediately after the observation. she stated that the door was to be locked. E17 went to check the door and stated something was QI committee quarterly until substantial

compliance is achieved.

Ongoing

PRINTED: 09/27/2011 EPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 ENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA ATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: DIPLAN OF CORRECTION A BUILDING C B. WING 085002 09/13/2011 WIE OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2801 W. 6TH STREET **ARKVIEW NURSING** WILMINGTON, DE 19805. PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ١D (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 323 Continued From page 9 F 323 treatment cart on the Westover unit unlocked with contents accessible to residents and visitors. The cart stored medicated ointments. In an interview with E10 (Nurse Supervisor) on 9/6/11, she confirmed the cart needed to be locked. 2. An observation of R49's room during the environmental tour with E11 (Maintenance Director) and E12 (Environmental Director) on 9/8/11 revealed a black bed electric cord on the floor that posed a potential tripping hazard. The electric bed cord was in the walking space of the floor in front of the bed. 3. An observation of R123's room during the environmental tour with E11 (Maintenance Director) and E12 (Environmental Director) on 9/8/11 revealed a black bed electric cord on the floor that posed a potential tripping hazard. The electric bed cord was in the walking space of the floor in front of the bed. 4. An observation of R137's room during the environmental tour on 9/8/11 revealed a long phone cord on the floor that posed a potential tripping hazard. The phone cord was in the #5 walking space of the floor in front of the bed. Shower door found on Lancaster Unit

cords each time.

In interviews with E11 on 9/8/11, he confirmed

second floor Lancaster unit (locked unit) revealed

an unlocked shower room. In an interview with

E17 (nurse) immediately after the observation,

she stated that the door was to be locked. E17

went to check the door and stated something was

the finding. E11 was observed relocating the

5. Observation on 9/6/11 at 8:50 AM of the

with broken lock was immediately

the importance of reporting any

In-service will be provided to all staff on

Audits will be conducted on all doors to

Maintenance Director will report to QI

committee quarterly until substantial

ensure locks are working properly.

repaired by maintenance.

maintenance issues.

compliance is achieved.

9/8/11

10/31/11

10/31/11

Ongoing

PRINTED: 09/27/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF		
		085002	B. WING		3/2011
	ROVIDER OR SUPPLIER		28	EET ADDRESS, CITY, STATE, ZIP CODE 101 W. 6TH STREET ILMINGTON, DE 19805	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371 SS=F	maintenance would 483.35(i) FOOD PF STORE/PREPARE The facility must - (1) Procure food fro considered satisfact authorities; and	ing mechanism and that be called. ROCURE, /SERVE - SANITARY om sources approved or ctory by Federal, State or local distribute and serve food	F 323		
	by: Based upon obser determined that the distribute and serve sanitary conditions Findings include: 1. On 9/6/11 at 10: the kitchen when sithe internal temper machine were 147 rinse gauges were respectively. This for proper sanitizat were coming out of encrusted debris. If were observed places	vations and interviews, it was a facility failed to prepare, a food to the residents under in the kitchen on 9/6/11. 15 AM, during a second visit of taff were using the dishwasher, ature readings of the dish PF. The external wash and reading 140°F and 150°F was below the 160°F required ion. Additionally, the plates the dishwasher with Dietary staff (E14 and E15) cing the soiled cleaned plates in the dishwasher machine at mes.	#* 2	 All dishes observed and not observed were placed through dish machine a second time after findings of booster not engaged. In-service was provided to all dietary staff on proper procedure for setting up the dishwasher. Dietary Aide #2 will verify Dietary Aide #1's recorded temperatures before dishwashing is conducted to ensure booster has been turned on and temp is within code. 	9/6/11 9/21/11 10/6/11

In an interview with E14 on 9/6/11, E14 was

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		085002	B. WING		C 09/13/2011
	PROVIDER OR SUPPLIER EW NURSING		280	ET ADDRESS, CITY, STATE, ZIP CODE D1 W. 6TH STREET ILMINGTON, DE 19805	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLÉTION
F 371	booster to heat up observed asking E on. E16 was then on. At 10:25 AM, it of the dishwasher 147°F, after the bolin an interview with on 9/6/11 at 2:30 F that set up and tun on was supposed the outside wash a confirmed this find	eyor if the dishwasher used a the water. The staff was 16 (Cook) if the booster was observed turning the booster ne internal temperature reading was 160°F, an increase from oster was turned on. In E13 (Food Services Director) PM, she stated that the staff ned the dishwasher machine to turn the booster on and log and rinse temperatures. E13 ing.	F 371		
	9/6/11 at 11:20 AM temperatures: - the mechanical Fahrenheit (F), - the puree chicke - the puree yam = - the puree cauliff All these temperate 135 F per the 2010 E16 (Cook) proceed chicken and handed at which point the serving the food. Eremoving the pans chicken, puree yar steam table and please the serving the serving the pans chicken, puree yar steam table and please the mechanical serving the pans chicken, puree yar steam table and please the mechanical serving the pans chicken, puree yar steam table and please the mechanical serving the pans chicken and please the mechanical serving the pure yar steam table and please the mechanical serving the pure yar steam table and please the mechanical serving the pure yar steam table and please the mechanical serving the pure yar serving the mechanical serving the pure yar serving the pure yar serving the mechanical serving the pure yar serving the pure yar serving the pure yar serving the pure yar	= 120°F,	#2 1. 2. 3.	Food temperature was brought up before serving the residents. Food temperatures will be record. Cook on temperature log. Secon and/or Designee will check temperature log will be reviewed and random audits conducted by Service Director and /or Designee accurate temperatures are within	9/6/11 ed by d Cook erature d. 10/6/11 weekly Food e to ensure code. 10/6/11

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

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(X3) DATE SURVEY

D85002 B. WING D85002 B. WING D9/13/2 STREET ADDRESS, CITY, STATE, ZIP CODE 2801 W. 6TH STREET WILMINGTON, DE 19805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPANDED.)	2011
PARKVIEW NURSING 2801 W. 6TH STREET WILMINGTON, DE 19805 (X4) ID PROVIDER'S PLAN OF CORRECTION	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) OMPLETION DATE
2. A second set of cups will be purchased to create an A and B grouping. All dietary staff will be in serviced on the rotation of groupings for use at meal time. 9/6/11 at 10:30 AM, an observation of the dishwasher operation revealed the food trays were stacked dripping wet as the staff stored them coming off the dishwasher exit. In an interview with E13 (Food Service Director) on 9/6/11, she confirmed this finding. She stated they have no space in the kitchen to place.	0/6/11 0/6/11 Ongoing

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		085002	B. WING		C 09/13/2011
	ROVIDER OR SUPPLIER		28	ET ADDRESS, CITY, STATE, ZIP CODE 01 W. 6TH STREET ILMINGTON, DE 19805	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION
*				DETICIENTY :	
F .371	Continued From pa	age 12	F 371		
	Director) on 9/6/11	, E16 stated that he used a	**		
	different process th	nan he normally uses. He			
	stated that he usua	ally used the steamer to keep			
	the food warm rath	er than the convection oven			
	which he used toda	ay. E16 stated he did not test			
	the food for temper	ratures when he removed the			
	food from the oven	and placed it in the steam			
	table. The facility h	ad no cooking temperature			
	logs for review.				
$\gamma_{ij} = (i+1)^{i+1}$					
	E13 and E16 on 9	/6/11 confirmed this finding.			
		o hold food under sanitary			
		itchen steam table per the			
	Food Code require	ements.			
		on 9/6/11 at 8:55 AM of the			
		ee cups (4 of 8) stored on the			
		evealed the cups were wet on			
		urface area of the cup. On			
		I, an observation of the			
		ion revealed the food trays			
		oing wet as the staff stored			
		e dishwasher exit. In an			
	1	(Food Service Director) on			
		ned this finding. She stated			
The same of the state of the same of the s		e in the kitchen to place	#4		
		ent to air dry the dish ware	1,		
	properly.			during observation had lids put o	
	A An observation	during the kitches tour es		at the moment.	9/6/11
		during the kitchen tour on	2.	Garbage barrels with foot pedal a attached lids will be purchased to	
		revealed a large garbage barrel		lids are on cans at all times.	10/6/11
		ruse was uncovered. The lid he floor and the barrel not in	3.		
			Ĭ	lid placement.	10/6/11
		taff was observed serving food	4.		
		9/12/11 at 2:43 PM, an kitchen area revealed one of		Administrator if any adverse fund	tions are
	1 .	with food refuse was		found.	Ongoing
and the second sections	1 (AAC 1 & IMPE DOING!)	WILL TOOK TOTAGE WAS	化二氯化乙酰胺 医多克氏		化电子电子 化二氯磺胺二氯氯苯甲基甲二甲基甲基甲基

OCIVICIO	TO THE DIGHTE	O MEDIOMID OF MACCO				OND NO.	0300-0031
STATEMENT O AND PLAN OF (F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU	100	IPLE CONSTRUCTION	(X3) DATE SU COMPLE	
			B. WII			(2
		085002] " "			09/1	3/2011
NAME OF PRO	OVIDER OR SUPPLIER V NURSING			2	REET ADDRESS, CITY, STATE, ZIP CODE 1801 W. 6TH STREET WILMINGTON, DE 19805		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE- (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
				. 1			/
1	ontinued From pa	-	F	371			
u	ncovered. One of	the two barrels was not in use.		- 7			
		ies were observed on the					
		barrels. This created a		4.5			
р	otential for pest ha	arborage.					
F 431 4	83.60(b), (d), (e) [DRUG RECORDS,	F	431			
		UGS & BIOLOGICALS					
T	he facility must en	nploy or obtain the services of		. 5.			
		cist who establishes a system					
		t and disposition of all		· ·		A section	
		sufficient detail to enable an	4.5				
		tion; and determines that drug					
		r and that an account of all					
		maintained and periodically					11/11/11
	econciled.	mamamod and periodically					
	scoricica.						
	ruge and highories	als used in the facility must be		1.1			
		nce with currently accepted		1.			
		oles, and include the	*				
		ory and cautionary					
		e expiration date when		M			
a	pplicable.						
1	oppordence with	Ctoto and Federal laws the					
		State and Federal laws, the					an especial de
		ll drugs and biologicals in	es e e forti Asian e e e e				
		its under proper temperature		Ż.			
		t only authorized personnel to					
h	ave access to the	keys.	10 A.	100	는 사람들은 일 등 사고를 하고 있다.		
		医医性性性 医医皮内囊结束					
		ovide separately locked,			【我看到你 法经济 计图片的		
		compartments for storage of					
		ed in Schedule II of the				그리고 화장	
		ug Abuse Prevention and		· 1 *			
		and other drugs subject to	Andrew Policy	gar in			
al	buse, except wher	n the facility uses single unit		4.1.			
		bution systems in which the			[1] 医克勒氏性皮肤 医多种 医二氏管		
		inimal and a missing dose can	11.11				
	e readily detected.						

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STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	l c	ATE SURVEY OMPLETED
		085002	B. WING		C 09/13/2011
	ROVIDER OR SUPPLIER EW NURSING		280	ET ADDRESS, CITY, STATE, ZIP CODE P1 W. 6TH STREET LMINGTON, DE 19805	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 431 F 502 SS=D	by: Based on observar determined that the expired medication 1. On 9/9/11 at 10:3 locked medication is Westover unit with medication refrigers (June 2011) vial of acknowledged that 2. On 9/9/11 at 11:4 locked medication is Lancaster unit with medication refrigers (June 2011) vial of acknowledged that 483.75(j)(1) ADMIN The facility must preservices to meet the facility is responsible of the services. This REQUIREMENT by: Based on record redetermined that the laboratory services	NT is not met as evidenced tion and interview, it was facility failed to dispose of s. Findings include: 50 AM, inspection of the room was completed on the E3 (nurse). Inspection of the ator revealed one expired influenza vaccine. E3 the vaccine was expired. 50 AM, inspection of the room was completed on the E5 (nurse). Inspection of the ator revealed one expired influenza vaccine. E5 the vaccine was expired.	# 1. 2. 3.	discarded when identified. All medication refrigerators and medicates were audited by the DON to ensumedications/vaccines were in date.	rre all 9/9/11 kly 9/12/11 erly
	include:				

		AND HUMAN SERVICES				FORM A	09/2//2011 APPROVED 0938-0391
TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MU		LE CONSTRUCTION (X	(3) DATE SU COMPLE	IRVEY
		085002	B. WIN	G		09/13	3/2011
NAME OF P	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	W NURSING				01 W. 6TH STREET	ander Dermande. Der State der State	
1 Altituit				W	ILMINGTON, DE 19805		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETION DATE
			•				
F 502	Continued From pa	age 15	F 5	02			
		physician's order sheet (POS)		F5	02		
		as to have a lipid profile, liver s) and a basic metabolic panel		1.	The missing labs were obtained when	n	
		y 6 months (August &			identified as being omitted.		9/8/11
	February).			2.	A random audit was completed on all		
					by the DON to ensure that all ordered	d labs	0/0/44
		clinical record revealed that on		3.	were obtained. In servicing will be provided by the St	taff	9/9/11
		ile and LFTs were drawn. A n until 5/18/11. Further review		J.	Educator to all nurses on following up		
		linical record lacked evidence			lab orders.		10/31/11
		LFTs and BMP having been		4.	A Quarterly QI will be initiated and	anel Iro	
	drawn in August, 2				monitored by the DON/Designee to e that all ordered labs are appropriate,		
			1.44	. ' .	been obtained and that the results ar		
		v with E4 (nurse) on 9/8/11 at		ė, i	available. This QI will continue until		Ongoing
	obtained as ordere	med that the labs had not been			substantial compliance is reached.		Ongoing
F 514	· ·	,	F 5	514			
SS=D		PLETE/ACCURATE/ACCESSIB					
	LE						
		naintain clinical records on each ance with accepted professional					
		ctices that are complete;					
		ented; readily accessible; and					
	systematically orga						
		must contain sufficient titify the resident; a record of the					
		nents; the plan of care and					
	services provided;						
	preadmission scre	ening conducted by the State;					
	and progress note	s. 1141 [1] 1					
and the first						3000	

This REQUIREMENT is not met as evidenced

Based on interview and record review the facility failed to maintain clinical records that were

	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	NG (X3) DATE:	ETED
		085002	B. WING _	09/	C 13/2011
	PROVIDER OR SUPPLIER EW NURSING			REET ADDRESS, CITY, STATE, ZIP CODE 2801 W. 6TH STREET WILMINGTON, DE 19805	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From pa	ge 16	F 514		
	complete and accur	ately documented for two (R8 irty-three (33) Stage II			
	diagnosis which inc Schizophrenia, Ost Vascular Disease w Peripheral Vascular Review of the Dupo	eoarthrosis, and Cerebral with right sided weakness and Disease nt Unit Meal and Intake Sheet	F	514 1	
	percent (%) % of th Dining observations	nented that R8 consumed 100 e meal for lunch. s on 9/6/11 at 12:30 PM d not consume 100% of the	1	 The meal intake record was reviewed by the Unit Manager and DON. A random audit was conducted by the DON 	9/9/11
	lunch meal. Collard apple crisp were ob clothing, over bed to	greens, sweet potatoes and served on the resident's able and floor. Approximately	3	on all units to ensure the accuracy of meal percentage documentation. In servicing will be provided by the Staff Educator on meal percentage calculation and documentation.	9/12/11 10/31/11
	secondary to spillag On 9/9/11 at 2:00 P Assistant/CNA) con have to clean up for resident after eating	M, E7 (Certified Nursing firmed that the CNA's always od off the floor and on the meals. E7 also stated that	4	The Staff Educator/Designee will complete a Quarterly QI on meal percentage calculation and document on accuracy until substantial compliance is achieved.	Ongoing
	of the percentage in	should not be counted as part take.			
	revealed that he wa	(Physician Order Sheet) s ordered to be on a 1200 ml	2	 The meal/fluid intake record was reviewed by the Unit Manager and DON. A random audit was completed by the DON on all units to ensure the accuracy of fluid 	9/13/11
	August 2011 "Food inaccurate documer	ction. Review of R149's Intake Record" revealed ntation for the total fluid mes. On 8/12/11, 8/16/11,	3	intake documentation. In-servicing will be provided to all nursing staff by the Staff Educator on fluid consumption calculation and	9/14/11
	drank 100% of his Nequaled 240 ml, yet	entation revealed that R149 Nepro (supplement) which the total amount consumed	4	documentation. The Staff Educator/Designee will complete a Quarterly QI on fluid consumption	10/31/11
	only 120 ml. On 8/2	es incorrectly documented as 28/11, it was documented that 0% of his supplement (240		documentation until substantial compliance is met.	Ongoing
					4. 19-4-51

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	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA DESCRIPTION SUPPLIER/CLIA DESCRIPTION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
	085002	B. WNG	C 09/13/2011
	ROVIDER OR SUPPLIER EW NURSING	STREET ADDRESS, CITY, STATE, ZIP CODE 2801 W. 6TH STREET WILMINGTON, DE 19805	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOTTING CROSS-REFERENCED TO THE APPROPRIES OF THE APPROPRI	OULD BE COMPLETION
F 514	Continued From page 17 ml) but incorrectly documented that R149 "R" (refused) fluid intake at his supper meal. On 8/30/11, for the breakfast meal, R149 drank 100% of his supplement (240 ML) but total fluids consumed at that meal were incorrectly documented as 120 ml. During an interview on 9/13/11, E6 (nurse) stated that the total fluid consumption for each meal should include any supplement consumed and these totals did not reflect that. The facility failed to accurately document R149's total fluid consumption for each meal.	F 514	



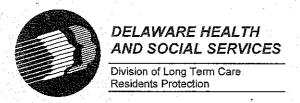
STATE SURVEY REPORT

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NAME OF FACILITY: Parkview Nursing Home	
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SECTION	STATEMENT OF DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION
	Specific Deficiencies	OF DEFICIENCIES WITH ANTICIPATED
		DATES TO BE CORRECTED
	An unannounced annual and complaint	
	survey was conducted at this facility from	
	September 6, 2011 through September 13,	
	2011. The deficiencies contained in this	
	report are based on observations,	
	interviews, review of resident's clinical	
	records and review of other documentation	
	as indicated. The facility census the first	
	day of the survey was 138. The Stage II	
	survey sample totaled 33 residents.	
	survey sample totaled 33 residents.	
3201	Skilled and Intermediate Care Nursing	
3201	Skilled and Intermediate Care Nursing Facilities	
	racilities	
2024 4 2		
3201.1.0	Scope	
3201.1.2	Nursing facilities shall be subject to all	
	applicable local, state and federal code	
	requirements. The provisions of 42 CFR	
	Ch. IV Part 483, Subpart B,	
	requirements for Long Term Care	
	Facilities, and any amendments or	
	modifications thereto, are hereby	
	adopted as the regulatory requirements	
	for skilled and intermediate care	
	nursing facilities in Delaware. Subpart	[하는데 남편물은 회교의 그리는 말을 하면 모음을 다른
	B of Part 483 is hereby referred to, and	
	made part of this Regulation, as if fully	
	set out herein. All applicable code	
	requirements of the State Fire	
	Prevention Commission are hereby	
	adopted and incorporated by reference.	
	This requirement is not met as	
	evidenced by:	
	Cross refer to the CMS 2567-L survey	[1] 그 보는 한번 맛있지? 하루 회의 보다 제속하는 것같다.
	report date completed 9/13/11, F278,	
	F280, F312, F323, F371, F431, F502, and	[교통 문학인 조금도 교육을 다 [[원모는 본 발표 호호]
	F514.	
3201.7.5	Kitchen and Food Storage Areas.	

Title <u>//</u>



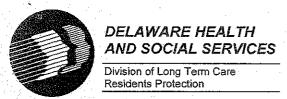
STATE SURVEY REPORT

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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTIO OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	N
· · · · · · · · · · · · · · · · · · ·			<u> </u>
The second second	Facilities shall comply with the		
	Delaware Food Code.		
	3-501.16 Potentially Hazardous Food		
	(Time/Temperature		
	Control for Safety Food), Hot and Cold		
	Holding.		
	(A) Except during preparation, cooking,		
	or cooling, or when time is used as the		
	public health control as specified under		
	§3-501.19, and except as specified		
	under ¶ (B) and in ¶ (C) of this section,		
	potentially hazardous food		
	(time/temperature control for safety		
	food) shall be maintained:	#2	
	(1) At 57°C (135°F) or above, except that	Food temperature was brought up to code	
	roasts cooked to a temperature and for	before serving the residents.	9/6/11
	a time specified in ¶ 3-401.11(B) or	Food temperatures will be recorded by	0.0111
	reheated as specified in ¶ 3-403.11(E)	Cook on temperature log. Second Cook	
	may be held at a temperature of 54°C	and/or Designee will check temperature accuracy before tray line is started.	40/0/44
	(130oF) or above; P or	Temperature log will be reviewed weekly	10/6/11
	(2) At 5°C (41°F) or less.	and random audits conducted by Food	
		Service Director and /or Designee to ensure	
	This requirement is not met as	accurate temperatures are within code. 4. Food Service Director will report to QI	10/6/11
	evidenced by:	committee results of audits until substantial	
		compliance is achieved	Ongoing
	Cross refer to the CMS 2567-L survey		O11901119
	report date completed 9/13/11, F371,		
	Example 2.		
	4-501.110 Mechanical Warewashing		
	Equipment, Wash Solution		
	Temperature.		
	(A) The temperature of the wash solution		
	in spray type warewashers that use hot		
	water to sanitize may not be less than:		
	(1) For a stationary rack, single		
	temperature machine, 74°C (165°F);		
	(2) For a stationary rack, dual temperature		
	machine, 66°C (150°F);		
	(3) For a single tank, conveyor, dual		
			5 5 TO 199 A

temperature machine, 71°C (160°F), or

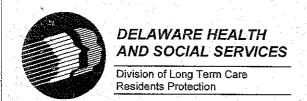
(4) For a multitank, conveyor,



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SECTION	STATEMENT OF DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION		
	Specific Deficiencies		EFICIENCIES WITH ANTICIPATED S TO BE CORRECTED	
	multitemperature machine, 66°C (150°F).	100		
		1.1		
	4-501.112 Mechanical Warewashing			
	Equipment, Hot Water Sanitization	#1		
	Temperatures.	1.	All dishes observed and not observed	
			were placed through dish machine a second time after findings of booster not	
	(A) Except as specified in ¶ (B) of this		engaged.	9/6/11
	section, in a mechanical operation, the	2.	In-service was provided to all dietary staff	
	temperature of the fresh hot water		on proper procedure for setting up the	s_1
	sanitizing rinse as it enters the manifold	7	dishwasher. Dietary Aide #2 will verify	
	may not be more than 90°C (194°F), or		Dietary Aide #1's recorded temperatures	
	less than:		before dishwashing is conducted to ensure booster has been turned on and temp is	
	(1) For a stationary rack, single		within code.	9/21/11
	temperature machine, 74°C (165°F); or	3	Temperature log will be reviewed weekly	
	(2) For all other machines, 82°C (180°F).		and random audits conducted by Food	
	(2) i oi ali otilei macililes, 02 e (100 i).	1	Service Director and/or Designee to	4010144
	This requirement is not met as		ensure accurate temps are recorded.	10/6/11
		4.	Food Service Director will report to QI committee results of audits until substantial	
	evidenced by:		compliance is achieved.	
	Crops refer to the CMC 2507 L		Compilation to dome to di	Ongoin
	Cross refer to the CMS 2567-L survey			
	report date completed 9/13/11, F371,			1, 1923
	Example 1.			
	4 004 44 Emiliana and and life and the			
	4-901.11 Equipment and Utensils, Air-			
	Drying Required.			
	After cleaning and sanitizing,			
	equipment and utensils:		[연안] 사람들은 하는 얼마 얼마 그리다니?	
	(A) Shall be air-dried or used after	#3		
	adequate draining as	1. :	Cups identified as being wet were not	
	specified in the first paragraph of 40		used for residents at meal time.	9/6/11
	CFR 180.940 Tolerance	2.	A second set of cups will be purchased to create an A and B grouping. All dietary	
	exemptions for active and inert		staff will be in serviced on the rotation of	
			groupings for use at meal time.	9/21/11
	ingredients for use in antimicrobial			
		3.	Weekly random audits will be conducted	
	ingredients for use in antimicrobial	3.	by Food Service Director and/or Designee	
	ingredients for use in antimicrobial formulations (food-contact surface	3.	by Food Service Director and/or Designee to ensure cups are being rotated in their	
	ingredients for use in antimicrobial formulations (food-contact surface sanitizing solutions), before contact		by Food Service Director and/or Designee to ensure cups are being rotated in their groupings.	10/6/11
	ingredients for use in antimicrobial formulations (food-contact surface sanitizing solutions), before contact with food; and	3. 4.	by Food Service Director and/or Designee to ensure cups are being rotated in their groupings. Food Service Director will report to QI	
	ingredients for use in antimicrobial formulations (food-contact surface sanitizing solutions), before contact with food; and (B) May not be cloth dried except that		by Food Service Director and/or Designee to ensure cups are being rotated in their groupings.	
	ingredients for use in antimicrobial formulations (food-contact surface sanitizing solutions), before contact with food; and		by Food Service Director and/or Designee to ensure cups are being rotated in their groupings. Food Service Director will report to QI committee results of audits until substantial	



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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	-	
	This requirement is not met as evidenced by:	
	Cross refer to the CMS 2567-L survey report date completed 9/13/11, F371, Example 3.	